Beginning Billing Workshop Home Health

Colorado Medicaid
2015

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Department of Health Care
Policy & Financing

Centers for Medicare & Medicaid Services

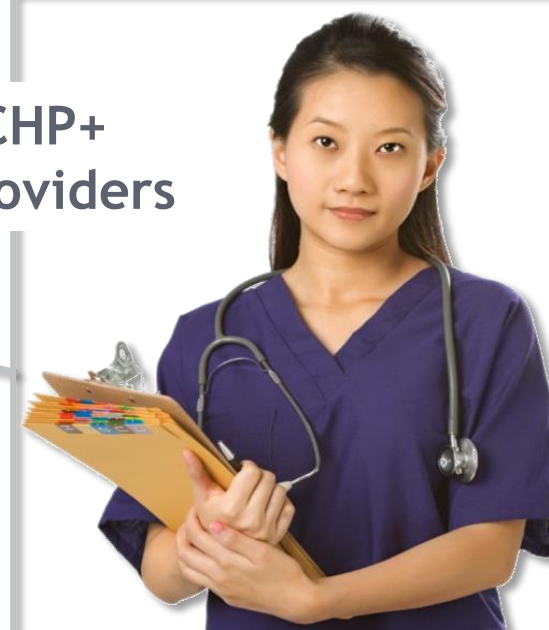**COLORADO** Department of Health Care Policy & Financing

Medicaid

Medicaid/CHP+ Medical Providers

Xerox State Healthcare

COLORADO Department of Health Care Policy & Financing

Training Objectives

- Billing Pre-Requisites
  - National Provider Identifier (NPI)
    - What it is and how to obtain one
  - Eligibility
    - How to verify
    - Know the different types

- Billing Basics
  - How to ensure your claims are timely
  - When to use the UB-04 paper claim form
  - How to bill when other payers are involved

What is an NPI?

- National Provider Identifier
- Unique 10-digit identification number issued to U.S. health care providers by CMS
- All HIPAA covered health care providers/organizations must use NPI in all billing transactions
- Are permanent once assigned
  - ➢ Regardless of job/location changes

What is an NPI? (cont.)

- How to Obtain & Learn Additional Information:
  - ➢ CMS web page (paper copy)-
    - ▪ www.dms.hhs.gov/nationalproldentstand/
  - ➢ National Plan and Provider Enumeration System (NPPES)-
    - ▪ www.nppes.cms.hhs.gov
  - ➢ Enumerator-
    - ▪ 1-800-456-3203
    - ▪ 1-800-692-2326 TTY

Department Website

Provider Home Page

Find what you need here

Contains important information regarding Colorado Medicaid & other topics of interest to providers & billing professionals

Provider Enrollment

Question:

What does **Provider** Enrollment do?

Answer:

Enrolls **providers** into the Colorado Medical Assistance Program, _not_ members

Question:

Who needs to enroll?

Answer:

Everyone who provides services for Medical Assistance Program members

Billing Providers

Billing Provider

Entity being reimbursed for service

Verifying Eligibility

- Always print & save copy of eligibility verifications
- Keep eligibility information in member's file for auditing purposes
- Ways to verify eligibility:

Colorado Medical Assistance Web Portal

Fax Back 1-800-493-0920

CMERS/AVRS 1-800-237-0757
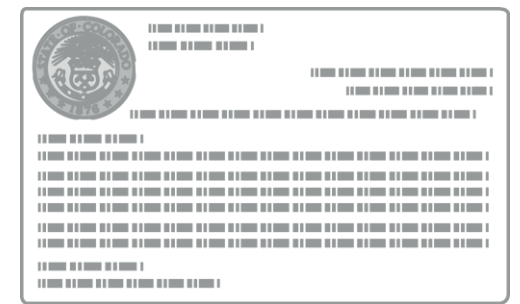
Medicaid ID Card with Switch Vendor

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From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Fax" by Vasily Ledovsky
"Telephone" by Edward Boatman

10

Eligibility Response Information

Eligibility Dates

Co-Pay Information

Third Party Liability (TPL)

Prepaid Health Plan

Medicare

Special Eligibility

BHO

Guarantee Number

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Eligibility Request Response (271)

Print

Eligibility Request

Provider ID: National Pro

From DOS: Through D

Client Detail

State ID: DOB:

Last Name: First Name

CO MEDICAL ASSISTANCE

Response Creation Date & Time: 05/19/2

Contact Information for Questions on Res
Provider Relations Number: 800-237-0751

Requesting Provider
Provider ID:
    Name:

Client Details
    Name:
State ID:

Return To Eligibility Inquiry

Client Eligibility Details

Eligibility Status: **Eligible**

Eligibility Benefit Date:
    04/06/2011 - 04/06/2011

Guarantee Number: **111400000000**

Coverage Name: Medicaid

PREPAID HEALTH PLAN OR ACCOUNTABLE CARE COLLABORATIVE

Eligibility Benefit Date:
    04/06/2011 - 04/06/2011

Messages:

MHPROV Services

Provider Name:

COLORADO HEALTH PARTNERSHIPS LLC

Provider Contact Phone Number:
    800-804-5008

Information appears in sections:
- Requesting Provider, Member Details, Member Eligibility Details, etc.
- Use scroll bar on right to view details

Successful inquiry notes a Guarantee Number:
- Print copy of response for member's file when necessary

Reminder:
- Information received is based on what is available through the Colorado Benefits Management System (CBMS)
- Updates may take up to 72 hours

Medicaid Identification Cards

- Both cards are valid
- Identification Card does not guarantee eligibility
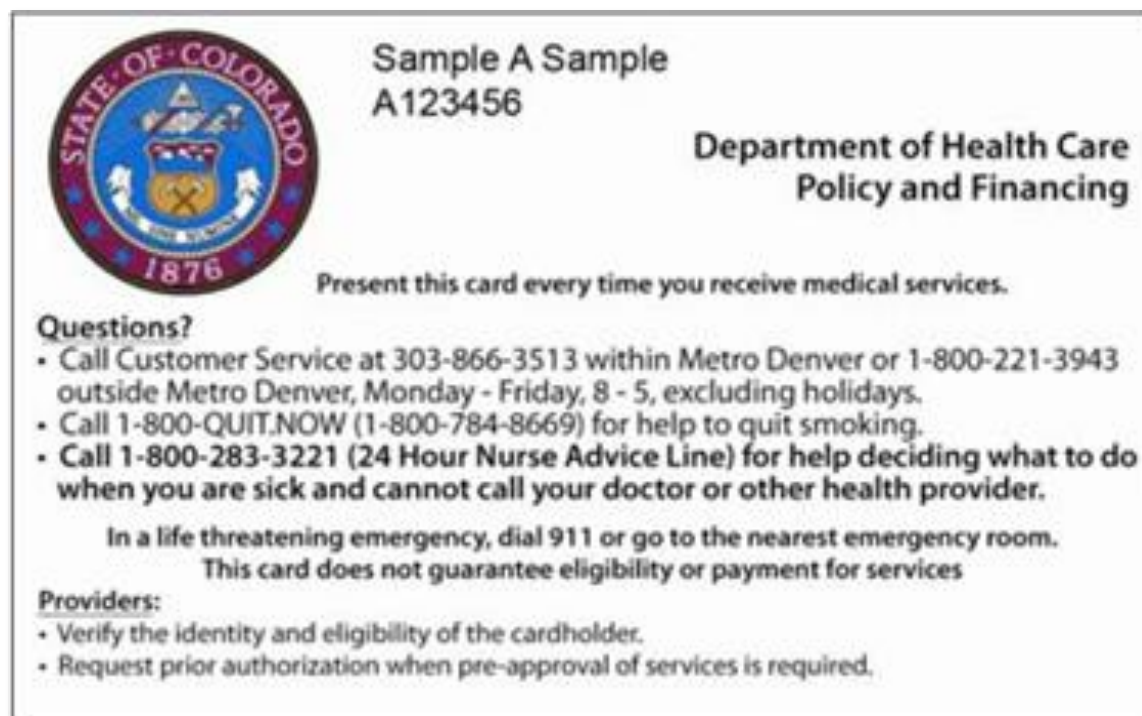
Eligibility Types

- Most members = Regular Colorado Medicaid benefits
- Some members = different eligibility type
  - Modified Medical Programs
  - Non-Citizens
  - Presumptive Eligibility
- Some members = additional benefits
  - Managed Care
  - Medicare
  - Third Party Insurance

Eligibility Types

Modified Medical Programs

- Members are not eligible for regular benefits due to income
- Some Colorado Medical Assistance Program payments are reduced
- Providers cannot bill the member for the amount not covered
- Maximum member co-pay for OAP-State is $300
- Does not cover:
  - Long term care services
  - Home and Community Based Services (HCBS)
  - Inpatient, psych or nursing facility services

Eligibility Types

Non-Citizens

- Only covered for admit types:
  - Emergency = 1
  - Trauma = 5
- Emergency services (must be certified in writing by provider)
  - Member health in serious jeopardy
  - Seriously impaired bodily function
  - Labor / Delivery
- Member may not receive medical identification care before services are rendered
- Member must submit statement to county case worker
- County enrolls member for the time of the emergency service only

What Defines an "Emergency"?

- Sudden, urgent, usually unexpected occurrence or occasion requiring immediate action such that of:
  - ➤ Active labor & delivery
  - ➤ Acute symptoms of sufficient severity & severe pain in which, the absence of immediate medical attention might result in:
    - ▪ Placing health in serious jeopardy
    - ▪ Serious impairment to bodily functions
    - ▪ Dysfunction of any bodily organ or part

Eligibility Types

Presumptive Eligibility

- Temporary coverage of Colorado Medicaid or CHP+ services until eligibility is determined
  - Member eligibility may take up to 72 hours before available
- Medicaid Presumptive Eligibility is only available to:
  - Pregnant women
    - Covers DME and other outpatient services
  - Children ages 18 and under
    - Covers all Medicaid covered services
  - Labor / Delivery
- CHP+ Presumptive Eligibility
  - Covers all CHP+ covered services, except dental

Eligibility Types

Presumptive Eligibility (cont.)

- Verify Medicaid Presumptive Eligibility through:
  - Web Portal
  - Faxback
  - CMERS
    - May take up to 72 hours before available
- Medicaid Presumptive Eligibility claims
  - Submit to the Fiscal Agent
    - Xerox Provider Services- 1-800-237-0757
- CHP+ Presumptive Eligibility and claims
  - Colorado Access- 1-888-214-1101

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Managed Care Options

Program of All-Inclusive Care for the Elderly (PACE)

Behavioral Health Organization (BHO)

Managed Care Organizations (MCOs)

Managed Care Options (MCOs)

Accountable Care Collaborative (ACC)
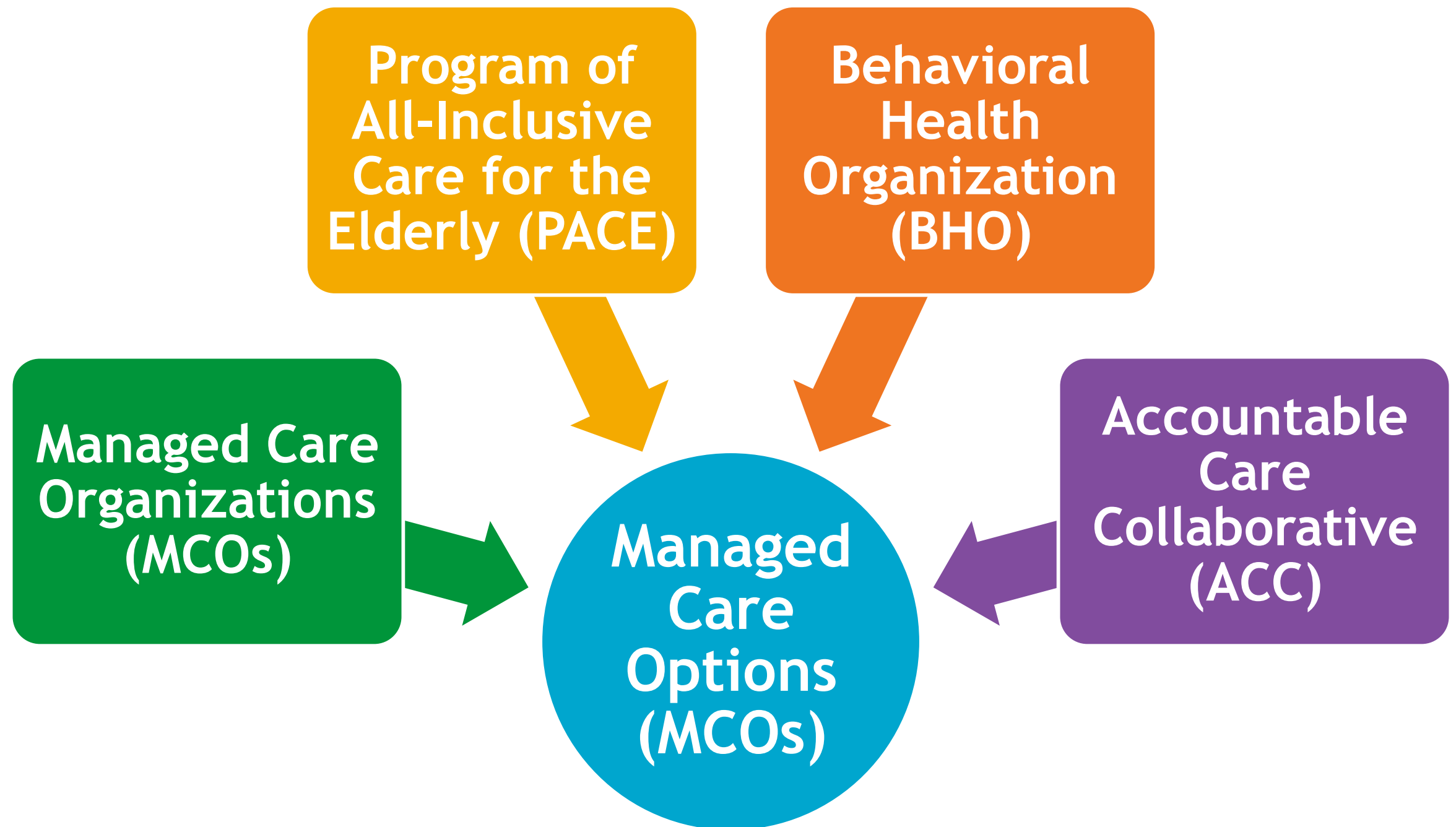
Managed Care Options

Managed Care Organization (MCO)

- Eligible for Fee-for-Service if:
  - ➢ MCO benefits exhausted
    - ▪ Bill on paper with copy of MCO denial
  - ➢ Service is not a benefit of the MCO
    - ▪ Bill directly to the fiscal agent
  - ➢ MCO not displayed on the eligibility verification
    - ▪ Bill on paper with copy of the eligibility print-out

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Managed Care Options

Behavioral Health Organization (BHO)

- Community Mental Health Services Program
  - State divided into 5 service areas
    - Each area managed by a specific BHO
  - Colorado Medical Assistance Program Providers
    - Contact BHO in your area to become a Mental Health Program Provider

Managed Care Options

Accountable Care Collaborative (ACC)

- Connects Medicaid members to:
  - ➤ Regional Care Collaborative Organization (RCCO)
  - ➤ Medicaid Providers
  - ➤ Connects Medicaid members to:
- Helps coordinate Member care
  - ➤ Helps with care transitions

Medicare

- Medicare members may have:
  - ➢ Part A only- covers Institutional Services
    - ▪ Hospital Insurance
  - ➢ Part B only- covers Professional Services
    - ▪ Medical Insurance
  - ➢ Part A and B- covers both services
  - ➢ Part D- covers Prescription Drugs

Medicare

Qualified Medicare Beneficiary (QMB)

- Bill like any other TPL

- Members only pay Medicaid co-pay

- Covers any service covered by Medicare

  - QMB Medicaid- members also receive Medicaid benefits

  - QMB Only- members do not receive Medicaid benefits

    - Pays only coinsurance and deductibles of a Medicare paid claim

Medicare

Medicare-Medicaid Enrollees

- Eligible for both Medicare & Medicaid
- Formerly known as "Dual Eligible"
- Medicaid is always payer of last resort
  - Bill Medicare first for Medicare-Medicaid Enrollee members
- Retain proof of:
  - Submission to Medicare prior to Colorado Medical Assistance Program
  - Medicare denials(s) for six years

Home Health

Medicare-Medicaid Enrollees

- If Medicare reimbursement for services are doubtful:
  - ➢ Give Medicare-Medicaid Enrollees Advance Beneficiary Notice (ABN)
    - ▪ Notice must be in CMS required format
    - ▪ Reason Medicare is expected not to pay must be specified and detailed
  - ➢ Instruct members to select third checkbox ("Option 3") indicating Medicare will be billed unless member chooses to self pay or not receive care
    - ▪ Member may then select option to not bill Medicare or any other insurance

Third Party Liability

- Colorado Medicaid pays Lower of Pricing (LOP)
  - Example:
    - Charge = $500
    - Program allowable = **$400**
    - TPL payment = **$300**
    - Program allowable – TPL payment = **LOP**

$$\begin{array}{r} \mathbf{\$400.00} \\ -\quad \mathbf{\$300.00} \\ =\quad \mathbf{\$100.00} \end{array}$$

Commercial Insurance

- Colorado Medicaid always payer of last resort
- Indicate insurance on claim
- Provider cannot:
  - Bill member difference or commercial co-payments
  - Place lien against members right to recover
  - Bill at-fault party's insurance

Billing Overview

Record Retention

Claim submission

Prior Authorization Requests (PARs)

Timely filing

Extensions for timely filing

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Record Retention

- Providers must:
  - Maintain records for at least 6 years
  - Longer if required by:
    - Regulation
    - Specific contract between provider & Colorado Medical Assistance Program
  - Furnish information upon request about payments claimed for Colorado Medical Assistance Program services

Record Retention

- Medical records must:
  - ➢ Substantiate submitted claim information
  - ➢ Be signed & dated by person ordering & providing the service
    - ▪ Computerized signatures & dates may be used if electronic record keeping system meets Colorado Medical Assistance Program security requirements

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Submitting Claims

- Methods to submit:
  - ➢ Electronically through Web Portal
  - ➢ Electronically using Batch Vendor, Clearinghouse, or Billing Agent
  - ➢ Paper only when:
    - ▪ Pre-approved (consistently submits less than 5 per month)
    - ▪ Claims require attachments

ICD-10 Implementation Delay

ICD-10 Implementation delayed until 10/1/2015

Claims with Dates of Service (DOS) **on** or **before** 9/30/15	Use ICD-9 codes
Claims with Dates of Service (DOS) **on** or **after** 10/1/2015	Use ICD-10 codes
Claims submitted with both ICD-9 and ICD-10 codes	Will be rejected

Providers Not Enrolled with EDI

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MEDICAL ASSISTANCE PROGRAM

Provider EDI Enrollment Application

Colorado Medical Assistance Program
PO Box 1100
Denver, Colorado 80201-1100
1-800-237-0757
colorado.gov/hcpf

Providers must be enrolled with EDI to:

- use the Web Portal
- submit HIPAA compliant claims
- make inquiries
- retrieve reports electronically
  - ➤ Select Provider Application for EDI Enrollment

Colorado.gov/hcpf/EDI-Support

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Crossover Claims

Automatic Medicare Crossover Process:

| Medicare | Fiscal Agent | Provider Claim Report (PCR) |
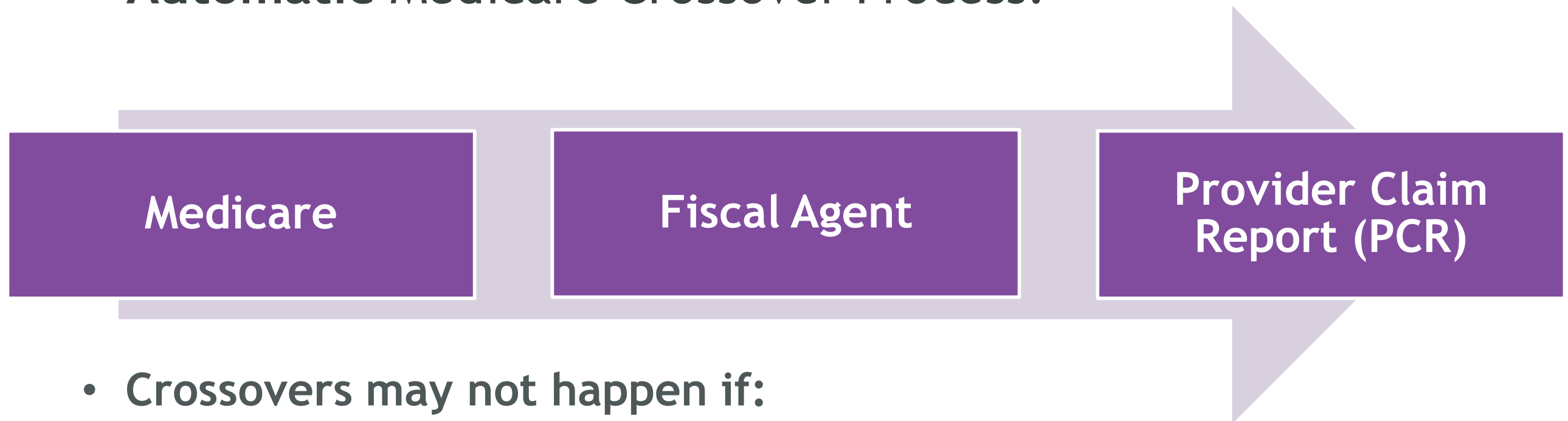
- **Crossovers may not happen if:**
  - ➤ NPI not linked
  - ➤ Member is a retired railroad employee
  - ➤ Member has incorrect Medicare number on file

Crossover Claims

Provider Submitted Medicare Crossover Process:

Medicare	Fiscal Agent	Provider Claim Report (PCR)

- **Additional Information:**
  - ➢ Submit claim yourself if Medicare crossover claim not on PCR within 30 days
  - ➢ Crossovers may be submitted on paper or electronically
  - ➢ Provider must submit copy of SPR with paper claims
  - ➢ Provider must retain SPR for audit purposes

Payment Processing Schedule

Mon.	Tue.	Wed.	Thur.	Fri.	Sat.

Mon. — Payment information is transmitted to the State's financial system

Accounting processes **E**lectronic **F**unds **T**ransfers (EFT) & checks

Wed. — Paper remittance statements & checks dropped in outgoing mail

Thur. — EFT payments deposited to provider accounts

Fri. — Weekly claim submission cutoff

Sat. — Fiscal Agent processes submitted claims & creates PCR
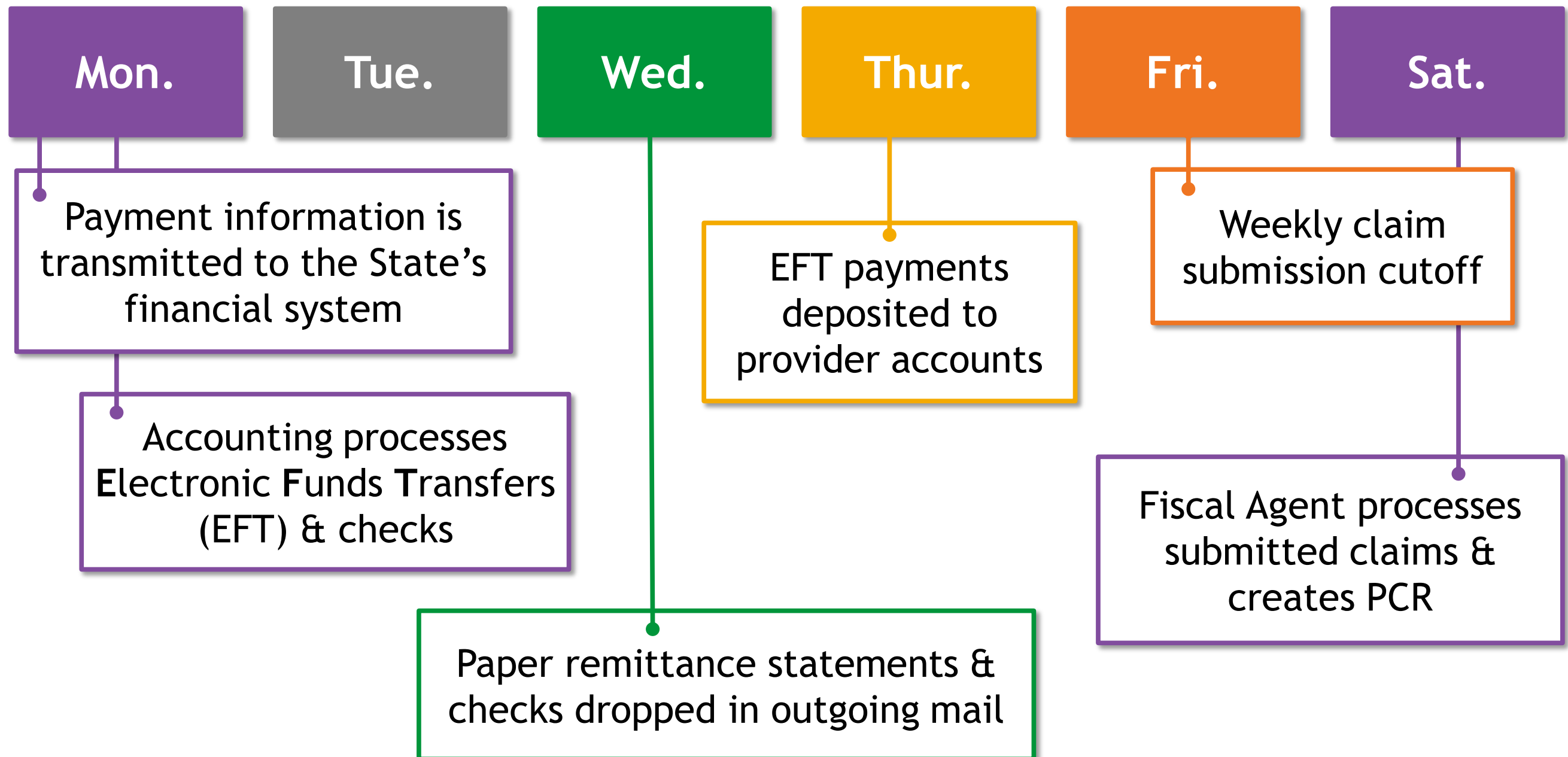
Electronic Funds Transfer (EFT)

Advantages

- Free!
- No postal service delays
- Automatic deposits every Thursday
- Safest, fastest & easiest way to receive payments
- Colorado.gov/hcpf/provider-forms → Other Forms

PARs Reviewed by ColoradoPAR

- With the **exception of Waiver and Nursing Facilities**:
  - ➢ The ColoradoPAR Program processes all PARs
    - ▪ including revisions
  - ➢ Visit ColoradoPAR.com for more information

Mail:	Phone:
Prior Authorization Request 55 N Robinson Ave., Suite 600 Oklahoma City, OK 73102	Phone: 1.888.454.7686 FAX: 1.866.492.3176 Web: ColoradoPAR.com

Electronic PAR Information

- PARs/revisions processed by the ColoradoPAR Program must be submitted via CareWebQI (CWQI)

- The ColoradoPAR Program will process PARs submitted by phone for:
  - emergent out-of-state
  - out-of area inpatient stays
  - e.g. where the patient is not in their home community and is seeking care with a specialist, and requires an authorization due to location constraints

PAR Letters/Inquiries

- Continue utilizing Web Portal for PAR letter retrieval/PAR status inquiries

- PAR number on PAR letter is only number accepted when submitting claims

- If a PAR Inquiry is performed and you cannot retrieve the information:
  - contact the ColoradoPAR Program
  - ensure you have the right PAR type
  - e.g. Medical PAR may have been requested but processed as a Supply PAR

Adult Long Term Home Health PAR

STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Assistance Program Prior Authorization

Adult Long Term Home Health

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1. CLIENT NAME	2. CLIENT ID	3. BIRTHDATE
5. REQUESTING PROVIDER #	6. REQUESTING AGENCY	7. CASE MANAGEMENT AGENCY #	8. DATES COVERED

8. DATES COVERED — From:

STATEMENT OF REQUESTED SERVICES

9. Revenue Code/ Description	10. Specify Frequency	11. # Units	12. Cost Per Unit	13. Total $ Requested	14. Total Units Authorized
551 RN/LPN			$103.11		
590 Uncomplicated Nursing Visit, 1			$72.18		
599 Uncomplicated Nursing Visit, 2+			$50.52		
571 Certified Nursing Assistant (CNA), Basic			$36.67		
579 Certified Nursing Assistant (CNA), Extended			$10.97		
A					
B					
C					
D					
E					
F					
G					
H					

17. TOTAL REQUESTED ADULT LONG TERM HOME HEALTH EXPENDITURES (SUM OF AMOUNTS IN COLUMN 13 ABOVE)

18. NUMBER OF DAYS COVERED (FROM FIELD 8 ABOVE)

19. ADDITIONAL INFORMATION:

CASE MANAGER USE

20. CASE MANAGER NAME	21. AGENCY	22. PHONE #	23. EMAIL
20A. CASE MANAGER SIGNATURE:			

DO NOT WRITE BELOW - AUTHORIZING AGENT USE ONLY

25. HOME HEALTH PAR: ☐ Approved Date: ☐ Denied Date: Return for

26. DENIAL REASON:

27. DEPARTMENT APPROVAL SIGNATURE: | 28. DATE:

1 of 4   LTHH   Created: 04/10/13   Revised: 02/04/15

Long Term Home Health PAR

Community Center Board Adult w/ DIDD

Supported Living Services (SLS)	Developmentally Disabled (DD)
Children's Extensive Support (CES)	Day Habilitation Services and Support (DHSS)

Long Term Home Health PAR

Case Management Agency
Adult & Children HCPF Waivers

Elderly Blind and Disabled (EBD)	Community Mental Health Services (CMHS)	Brain Injury (BI)	Spinal Cord Injury (SCI)

Children's Home Community Based Services (CHCBS)	Children With Autism (CWA)	Children with Life Limiting Illness (CLLI)

Transaction Control Number

Receipt Method
0 = Paper
2 = Medicare Crossover
3 = Electronic
4 = System Generated

Batch Number

Document Number

0 15 129 00 150 0 00037

Year of Receipt

Julian Date of Receipt

Adjustment Indicator
1 = Recovery
2 = Repayment
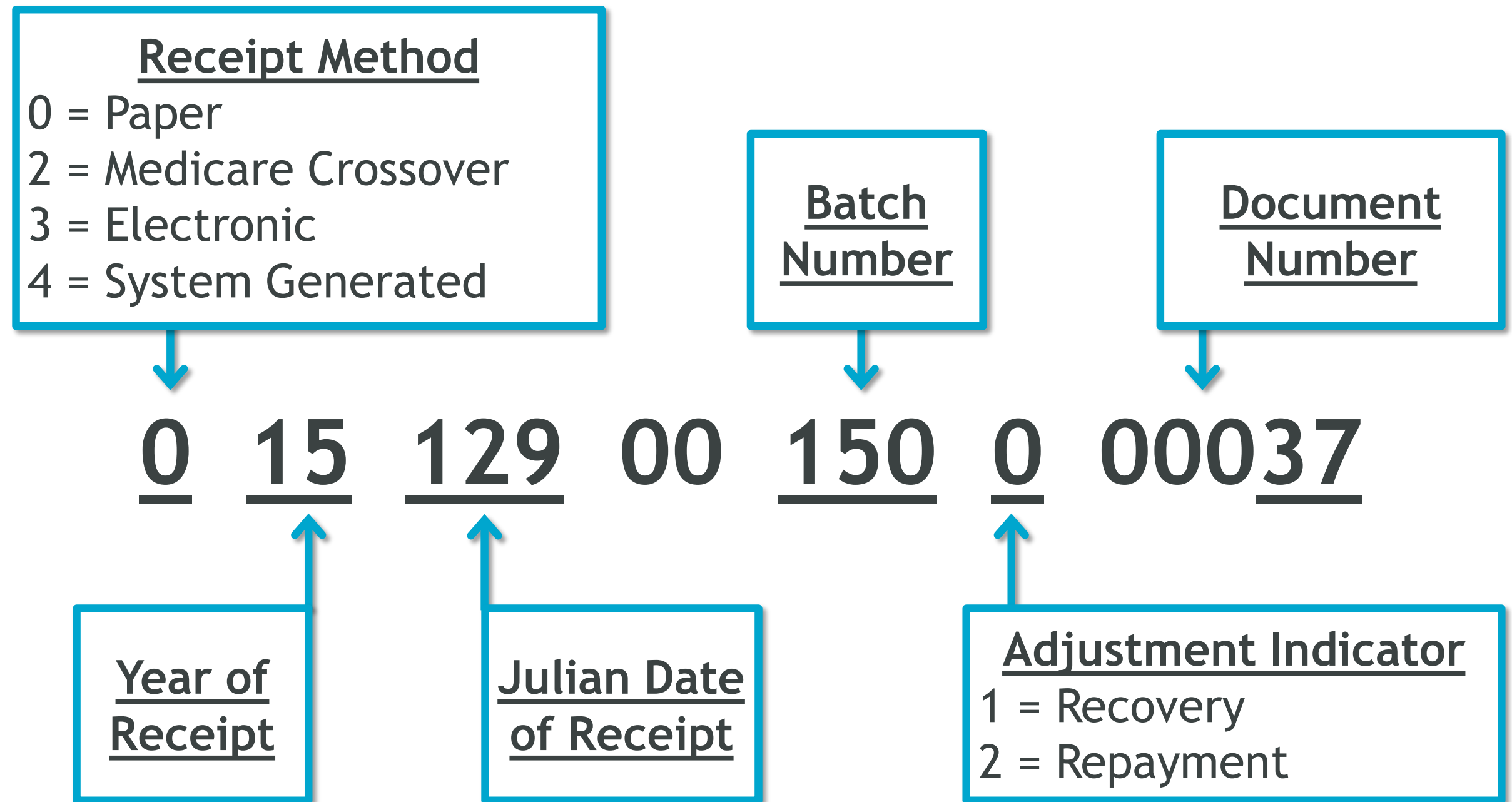
Timely Filing

- 120 days from Date of Service (DOS)
  - Determined by date of receipt, not postmark
  - PARs are not proof of timely filing
  - Certified mail is not proof of timely filing
  - Example – DOS January 1, 20XX:
    - Julian Date: 1
    - Add: 120
    - Julian Date = 121
    - Timely Filing = Day 121 (May 1st)

Timely Filing

From "through" DOS

- Nursing Facility
- Home Health
- Waiver
- In- & Outpatient
- UB-04 Services

From delivery date

- Obstetrical Services
- Professional Fees
- Global Procedure Codes:
- Service Date = Delivery Date

From DOS

FQHC Separately Billed and additional Services

Documentation for Timely Filing

- 60 days from date on:
  - Provider Claim Report (PCR) Denial
  - Rejected or Returned Claim
  - Use delay reason codes on 837I transaction
  - Keep supporting documentation
- Paper Claims
  - UB-04- enter Occurrence Code 53 and the date of the last adverse action

Timely Filing

Medicare/Medicaid Enrollees

Medicare pays claim

120 days from Medicare payment date

Medicare denies claim

60 days from Medicare denial date

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Timely Filing Extensions

- Extensions may be allowed when:
  - ➢ Commercial insurance has yet to pay/deny
  - ➢ Delayed member eligibility notification
    - ▪ Delayed Eligibility Notification Form
  - ➢ Backdated eligibility
    - ▪ Load letter from county

Timely Filing Extensions

Commercial Insurance

- 365 days from DOS

- 60 days from payment/denial date

- When nearing the 365 day cut-off:

    - File claim with Colorado Medicaid

        - Receive denial or rejection

    - Continue re-filing every 60 days until insurance information is available

Timely Filing Extensions

Delayed Notification

- 60 days from eligibility notification date
  - Certification & Request for Timely Filing Extension – Delayed Eligibility Notification Form
    - Located in Forms section
    - Complete & retain for record of LBOD

- Bill electronically
  - If paper claim required, submit with copy of Delayed Eligibility Notification Form

- Steps you can take:
  - Review past records
  - Request billing information from member

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Timely Filing Extensions

Backdated Eligibility

- 120 days from date county enters eligibility into system
  - Report by obtaining State-authorized letter identifying:
    - County technician
    - Member name
    - Delayed or backdated
    - Date eligibility was updated

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UB-04

What services are billed on the UB-04?

Uncomplicated Nursing Visit	CNA Services

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UB-04

UB-04 is the standard institutional claim form used by Medicare and Medicaid Assistance Programs

Where can a Colorado Medical Assistance provider get the UB-04?

- Available through most office supply stores
- Sometimes provided by payers

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UB-04 Certification

Colorado Medical Assistance Program

Institutional Provider Certification

This is to certify that the foregoing information is true, accurate and complete.

This is to certify that I understand that payment of this claim will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

Signature:_____ Date:_____

This document is an addendum to the UB-04 claim form and is required per 42 C.F.R. 445.18 (a)(1-2) to be attached to paper claims submitted on the UB-04.

Revised March 2015

UB-04 certification must be completed & attached to all claims submitted on the paper UB-04

Print a copy of the certification at:

Colorado.gov/hcpf/billing-manuals

UB-04 Tips

Do	Submit multiple-page claims electronically

Do Not	- Submit "continuous" claims - Add more lines on the form - Each claim form has set number of available billing lines - Billing lines in excess of designated number are not processed or acknowledged

UB-04 Coding Reminders

Use Value Codes to indicate

Patient Liability (Patient Payment)

- Value Code 31

Covered Days

- Value Code 80

Non-Covered Days

- Value Code 81

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UB-04 Coding Reminders

Statement Covers Period
"From" and "Through" dates must be within same calendar month

Acute Home Health

- When member transfers from one home health provider to another, new provider must contact previous provider to learn:
  - ➢ If acute services were billed
  - ➢ First & last date of service of most current acute episode
    - ▪ This information allows provider to perform and bill acute services according to 60-day rule

Acute Home Health

Acute episode

Does not mean 60 days of services

- starts on first date of service billed & continues for:
  - ➢ Up to 60 calendar days,
  - ➢ or until condition stabilizes or resolves,
  - ➢ or whichever comes first

Hospitalizations or discharges do not restart episode

Acute episode may start on Julian date 001 & may last through Julian date 060

- Next episode cannot start until Julian date 071 (10 calendar days)
- Must be new or change in condition

When a member is expected to need more than 60 calendar days of care

Provider must evaluate member and complete Long-Term Home Health (LTHH) PAR prior to end of the 60 day period

Long Term Home Health

- Submit claims for LTHH & Acute HH revenue codes on separate claims
  - ➢ If LTHH and Acute HH services are submitted on same claim (or same dates of service) claim will deny
  - ➢ Processing system counts denied services as part of an acute 10-day break period
- Dates on CMS 485 must include PAR start-of-care dates

Common Home Health Denial Reasons

Prior Authorization / Service date conflict	EPSDT PDN Condition Code is missing or invalid
LTHH and Acute HH revenue codes on same claims	LTHH / Acute HH conflict
If member in Managed Care Organization (MCO), bill Acute HH to the MCO	LTHH / Acute HH is over daily limit
Acute and Long Term Care billed for same date of service	Total Charge conflict

Claims Process - Common Terms

Reject
Claim has primary data edits – **not** accepted by claims processing system

Denied
Claim processed & denied by claims processing system

Accept
Claim accepted by claims processing system

Paid
Claim processed & paid by claims processing system

Claims Process - Common Terms

Adjustment
Correcting under/overpayments, claims paid at zero & claims history info
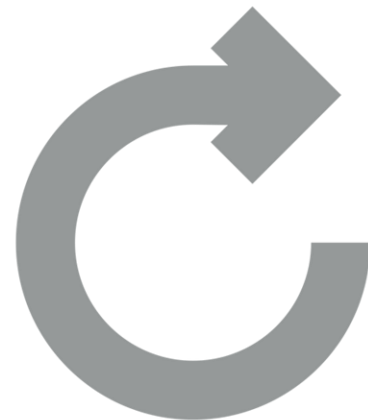
Rebill
Re-bill previously denied claim

Suspend
Claim must be manually reviewed before adjudication

Void
"Cancelling" a "paid" claim (wait 48 hours to rebill)

Adjusting Claims

- What is an adjustment?
  - ➢ Adjustments create a replacement claim
  - ➢ Two step process: Credit & Repayment

Adjust a claim when	Do not adjust when
• Provider billed incorrect services or charges • Claim paid incorrectly	• Claim was denied • Claim is in process • Claim is suspended

Adjustment Methods

Web Portal

- Preferred method
- Easier to submit & track

Paper

- Complete Adjustment Transmittal form
- Be concise & clear

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From the Noun Project:
"Internet" by OCHA Visual Information Unit
"Paper" by Kristina

68

Provider Claim Reports (PCRs)

- Contains the following claims information:
  - ➢ Paid
  - ➢ Denied
  - ➢ Adjusted
  - ➢ Voided
  - ➢ In process
- Providers required to retrieve PCR through File & Report Service (FRS)
  - ➢ Via Web Portal

Provider Claim Reports (PCRs)

- Available through FRS for 60 days
- Two options to obtain duplicate PCRs:
  - Fiscal agent will send encrypted email with copy of PCR attached
    - $2.00/ page
  - Fiscal agent will mail copy of PCR via FedEx
    - Flat rate- $2.61/ page for business address
    - $2.86/ page for residential address
- Charge is assessed regardless of whether request made within 1 month of PCR issue date or not

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Provider Claim Reports (PCRs)

Paid

```
                                    * C L A I M S   P A I D *
                                    ****************************

INVOICE  ------------ CLIENT ------------        TRANSACTION    DATES OF SVC   TOTAL   ALLOWED  COPAY  AMT OTH   CLM PMT
  NUM    --------  NAME --------  STATE ID  CONTROL NUMBER  FROM   TO   CHARGES  CHARGES  PAID   SOURCES   AMOUNT
  7015          CLIENT, IMA     Z000000  0408000000000001 040508 040508  132.00    69.46   2.00    0.00      69.46
PROC CODE - MODIFIER 99214 -                                040508 040508  132.00    69.46   2.00
        TOTALS - THIS PROVIDER / THIS CATEGORY OF SERVICE .... TOTAL CLAIMS PAID    1      TOTAL PAYMENTS         69.46
```

Denied

```
                                    * C L A I M S   D E N I E D *
                                    *******************************

INVOICE     ------------    CLIENT    --------------------    TRANSACTION     DATES OF SERVICE     TOTAL  ----- DENIAL REASONS ----
  NUM       -----------     NAME      ----------  STATE ID  CONTROL NUMBER     FROM      TO        DENIED ------ ERROR CODES -----
STEDOTCCIOT           CLIENT, IMA            A000000  3080000000000003  03/05/08 03/06/08  245.04          1348
        TOTAL CLAIMS DENIED - THIS PROVIDER / THIS CATEGORY OF SERVICE    1
```

THE FOLLOWING IS A DESCRIPTION OF THE DENIAL REASON (EXC) CODES THAT APPEAR ABOVE:

1348   The billing provider specified is not a fully active provider because they are enrolled in an active/non-billable status of '62', '63', '64', or '65 for the FDOS on the claim. These active/non-billable providers can't receive payment directly. The provider must be in a fully active enrollment status of '60' or '61'.

HCPF
CO
COLORADO
Department of Health Care
Policy & Financing

Provider Claim Reports (PCRs)

Adjustments

Recovery

```
                                        **************************************
                                        * A D J U S T M E N T S   P A I D *
                                        **************************************

INVOICE  ---  CLIENT       ----------       TRANSACTION   DATES OF SVC  ADJ    TOTAL    ALLOWED  COPAY   AMT OTH   CLM PMT
  NUM   ------ NAME ------  STATE ID   CONTROL NUMBER  FROM   TO   RSN  CHARGES  CHARGES  PAID   SOURCES  AMOUNT
Z71       CLIENT, IMA    A000000   4080000000100002 041008 041808 406   92.82-   92.82-   0.00    0.00    92.82-
PROC CODE - MOD  T1019 - U1              041008 091808    92.82   92.82-
Z71       CLIENT, IMA    A000000   4080000000200002 041008 041808 406   114.24   114.24   0.00    0.00    114.24
PROC CODE - MOD  T1019 - U1              041008 041808   114.24   114.24-
                                                        NET IMPACT   21.42
```

Repayment

Net Impact

Voids

```
                                        **************************************
                                        * A D J U S T M E N T S   P A I D *
                                        **************************************

INVOICE – CLIENT      --------------------   TRANSACTION   DATES OF SVC  ADJ    TOTAL    ALLOWED  COPAY   AMT OTH   CLM PMT
NUM  ------  NAME ------- STATE ID   CONTROL NUMBER  FROM   TO   RSN  CHARGES  CHARGES  PAID   SOURCES  AMOUNT
A83        CLIENT, IMA   Y000002   4080000000100009 040608 042008 212   642.60-   642.60-   0.00    0.00    642.60-
PROC CODE - MOD  T1019 - U1              040608 042008    642.60-   642.60-
                                                        NET IMPACT   642.60-
```

Provider Services

Xerox
1-800-237-0757

- Claims/Billing/Payment
- Forms/Website
- EDI
- Enrolling New Providers
- Updating existing provider profile

CGI
1-888-538-4275

- Email helpdesk.HCG.central.us@cgi.com
- CMAP Web Portal technical support
- CMAP Web Portal Password resets
- CMAP Web Portal End User training

Thank you!